100th Congress
2d Session

HOUSE COMMITTEE PRINT NO. 14

STAFF SITE VISITS TO VETERANS' ADMINISTRATION MEDICAL CENTERS

REPORT TO COMMITTEE ON VETERANS' AFFAIRS

MAY 31, 1988.—Printed for the use of the Committee on Veterans' Affairs of the House of Representatives

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U.S. GOVERNMENT PRINTING OFFICE

85-555 ⇆ WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

H762-6.

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STAFF SITE VISITS TO VETERANS' ADMINISTRATION MEDICAL CENTERS

INTRODUCTION

During the week of April 4, 1988, four staff members of the Committee on Veterans' Affairs made site visits to 16 VA medical centers. Questions asked during the site visits were derived from testimony received during Committee hearings and from informal information from inside and outside the VA. Categories of questions included bed levels, staffing and management. The staff used a semi-structured survey form so that similar information would be gathered during the visits.

METHODS

The method of conducting the survey consisted of site-selection, site visits and information collection, and analysis of information. The survey form used is attached in Appendix A.

The sites were not randomly selected in a scientific sense, but instead were chosen to represent various sections of the country: west, mid-west, northeast and southeast. The specific facilities visited will not be identified as the detail of conditions at any one hospital is less the purpose of this report than to identify patterns within the VA medical care system.

For the most part, the medical facilities which were surveyed were located in metropolitan areas, although three were located in what might be considered rural or at least non-urban areas. Facility directors were given no more than 2 days notice of the visits and no specific questions were provided in advance. Facilities reported current operating information.

The major concern of the site visits was the capacity of the medical centers to deliver health care to veterans, in terms of both the number of beds available and medical personnel to staff the beds.

With regard to beds, Title 38, United States Code, section 5010 requires the VA Administrator to "establish the total number of hospital beds and nursing home beds in medical facilities over which the Administrator has direct jurisdiction for the care and treatment of eligible veterans at not more than 125,000 and not less than 100,000. The Administrator shall establish the total number of such beds so as to maintain a contingency capacity to assist the Department of Defense in time of war or national emergency to care for the casualties of such war or national emergency. Of the number of beds authorized pursuant to the preceding sentence, the Administrator shall operate 90,000 hospital beds and nursing home beds and shall maintain the availability of such additional beds and facilities in addition to the operating bed level as

the Administrator considers necessary for such contingency purposes...the Administrator shall staff and maintain, in such a manner as to ensure the immediate acceptance and timely and complete care of patients, sufficient beds and other treatment capacities to accommodate, and provide such care to, eligible veterans applying for admission and found to be in need of hospital care or medical services."

There has been reference among VA employees for several years to the concept of "phantom beds". Phantom beds are those beds which are officially operating beds for purposes of complying with section 5010 of Title 38, United States Code, but which are not staffed and available for patient care. Thus, to the extent that such beds are classified as "operating" beds, there is lack of compliance with Title 38.

One of the reasons cited for deficits in available beds is insufficient personnel to adequately staff them. Therefore, the second section of the survey addressed the existence of staff shortages, the use of special salary rates for combating such shortages and their associated funding sources. Special salary rates are increases in pay awarded to individuals in medical occupations for which there are demonstrated recruitment and retention difficulties. The amounts of increase are derived from prevailing local wages for the occupation.

The third section contained a variety of general questions about funding problems in fiscal year 1988, Office of Management and Budget Circular A-76 contracting activities and Facility Development Plans.

The VA, along with other federal agencies, is required by the Office of Management and Budget Circular A-76 (revised) to conduct cost-comparison studies of certain functions that have been designated as "commercial activities" to determine if such activities will continue to be performed in-house or under contract with commercial sources. Title 38, U.S.C., section 5010 requires that an A-76 cost-comparison study be completed before any activity can be converted from one performed by Federal employees to one performed by employees of a contractor. Functions in support of direct patient care or incident to direct patient care are exempted from A-76 requirements. The VA's Department of Medicine and Surgery has designated the following as "Commercial Activities": chauffeur, design/drafting, fire protection, furniture repair, grounds maintenance, printing/reproduction, laundry/dry cleaning, messenger, switchboard, transcription, Veterans Canteen Service food operations, and warehouse.

For inherently "governmental" activities, Most Efficient Organization (MEO) cost-comparison studies are required by the Office of Management and Budget to increase productivity. The VA defines activities covered by MEO studies to include: dietetics, housekeeping, office operations, plant maintenance, and medical information.

Facility Development Plans are part of a relatively new VA organizational structure which is intended to bring a more rational and cost-effective basis to medical facility construction and mainte-

nance. The new structure was established notwithstanding Committee objections to separating the medical facility construction planning and implementation function from the Department of Medicine and Surgery.

Chart A

TOTAL BEDS (AUTHORIZED, OPERATING, AVAILABLE) BY HOSPITAL *

Hospital	Total Beds			Beds Closed	
	Authorized	Operating	Available	For Staff Short	% Closed of Operating
A	1,182	1,060	959	101	9.5
B	670	553	442	111	20.0
C	519	398	388	10	2.5
D	1,566	1,383	1,206	0	0
E	1,314	1,314	1,314	0	0
F	515	446	412	34	7.6
G	514	436	396	40	9.2
H	822	775	567	208	26.8
I	752	604	435	169	27.9
J	958	901	791	109	12.1
K	683	663	547	116	17.5
L	760	606	386	220	36.3
M	2,019	1,528	1,127	401	26.2
N	885	748	631	117	15.6
O	1,232	1,031	1,031	0	0
P	548	514	379	135	26.3
Total	14,939	12,960	11,011	1,771	13.7

* Totals will not resolve as beds are also closed for reasons other than staff shortages.

Results

Chart A displays total authorized, total operating and total available bed levels for the 16 hospitals that were visited. As can be seen, 1,771 beds were identified by hospital management as closed due to insufficient staff. This number is 13.7 percent of the total operating beds in these 16 hospitals. Many other beds are closed for such reasons as construction and renovation, but this survey addresses beds that were closed due to staff shortages.

However, as can be seen, the problem of closed beds is not the same at all hospitals. Three individual hospitals have no beds shut down due to staff shortages. The proportion of operating beds which are closed due to inadequate staff in the other individual hospitals range from 2.5 percent to 36.3 percent. In hospitals that do have staff shortages leading to closed beds, the average proportion of operating beds which are not adequately staffed is 19.1 percent.

It is important to know that these beds are not officially closed. Officially closed beds are reflected in the number of operating beds. Hospital directors have been refused authority to officially close beds due to inadequate staff. Presumably, this is due to the 90,000 bed minimum established in Title 38.

Chart B

SPECIAL PAY POSITIONS BY HOSPITAL

Hospital	Special Pay Positions	Funding Source	Adequate Funding
A	LPN, GS–3/4/5; RN, Jr/Assoc/full	VACO	YES
	PHARMACISTS, PHYSICAL THERAPISTS	LOCAL MEDICAL CENTER	YES
B	REGISTERED NURSES	VACO	YES
	DIAGNOSTIC AND THERAPEUTIC RADIOLOGIC TECHNICIANS	LOCAL	NO
	PHARMACISTS, PHYSICAL THERAPISTS	LOCAL	NO
C	REGISTERED NURSES, NURSE ANETHESTISTS	VACO 80%, FACILITY 20%	NO
	PHARMACISTS, ENGINEERS	VACO 80%, FACILITY 20%	NO
	RADIOLOGY TECHNICIANS, ULTRASOUND TECHNICIANS	VACO 80%, FACILITY 20%	NO
D	REGISTERED NURSES	VACO 50%, REGION 10%, LOCAL 40%	*
	PHARMACISTS, SECURITY OFFICERS	VACO 70%, REGION 15%, LOCAL 15%	*
	ENGINEERS	LOCAL 100%	*
E	PHYSICIAN SPECIALTIES: ANESTHESIOLOGY, ORTHOPEDIC SURGERY,		
	PHYSIATRY, RADIOLOGY, PATHOLOGY	*	YES
	PHARMACISTS	*	YES
F	REGISTERED NURSES	VACO, REGION, LOCAL	NO
	PHARMACISTS	VACO, REGION, LOCAL	NO
G	REGISTERED NURSES	VACO 40%	YES
	PHARMACISTS	REGION 40%	YES
	SECURITY OFFICERS, PHYSICAL THERAPISTS	LOCAL 20%	NO
H	REGISTERED NURSES, LPNs, PHARMACISTS, CERTIFIED AND REGISTERED	*	NO
	RESPIRATORY TECHNICIANS, MEDICAL RECORDS STAFF, DIETICIANS, ENGINEERS,		*
	OCCUPATIONAL AND PHYSICAL THERAPISTS, SECURITY OFFICERS		*
I	REGISTERED NURSES, PHARMACISTS	*	NO
	RADIOLOGY TECHNICIANS	*	NO
	SECURITY OFFICERS	*	NO
J	REGISTERED NURSES, LPN's, RADIOLOGY TECHNICIANS	LOCAL	NO
	OCCUPATIONAL THERAPISTS, PHYSICAL THERAPISTS,	LOCAL	NO
	PHARMACISTS, DENTAL HYGIENISTS, SECURITY OFFICERS	LOCAL	NO

K	REGISTERED NURSES, LPN's, PHARMACISTS, RADIOLOGY TECHNICIANS	*	*
	OCCUPATIONAL AND PHYSICAL THERAPISTS, RESPIRATORY THERAPISTS, MEDICAL	*	*
	TECHNOLOGISTS, MEDICAL TECHNICIANS, PHYSICIAN ASST's, SECURITY OFFICERS	*	*
L	REGISTERED NURSES	*	*
		*	*
		*	*
M	REGISTERED NURSES, LPN's, RADIOLOGY TECHNICIANS,	*	NO
	CERTIFIED RESPIRATORY TECHNICIANS, HEART/LUNG MACHINE TECHNOLOGISTS	*	NO
	PHARMACISTS	*	NO
N	REGISTERED NURSES, PHARMACISTS, DIAGNOSTIC RADIOLOGIC TECHNOLOGISTS	VACO	YES
	OT, PT, RESPIRATORY TECH's, MEDICAL TECH's, ENGINEERS, NURSE ANESTH's	LOCAL	NO
	DENTAL HYGIENISTS, HISTOPATHOLOGY TECH's, MEDICAL RECORD TECH's, SECURITY, LVN's	LOCAL: REGION (LVN)	NO
O	REGISTERED NURSES, PHARMACISTS, RADIOLOGY TECH's, OT's, PT's, RT's	VACO	YES
	SECURITY, MEDICAL RECORD TECH's, LVN's	VACO 80%; VAMC 20%	NO
	DENTAL HYGIENISTS	REGION 50%; VAMC 50%	NO
P	REGISTERED NURSES, PHARMACISTS	LOCAL, VACO	NO
	PT's, DENTAL HYGIENISTS, ENGINEERS	LOCAL	NO
	MEDICAL TECH's, LVN's	VACO	YES

* Information not provided by medical center.

Chart B displays the health care occupations in which special salary rates are being used, together with the funding sources and a determination by the hospital as to the adequacy of extra funding for the added costs. In the case of Hospital G, there are special bonus and Scarce Medical and Dental Specialty Bonus arrangements in effect for 5 physician specialties. However, the bulk of reported staff shortages which lead to bed closures are in non-physician staff specialties. As can be seen, funding of the special rates is often not adequate.

Chart C

SPECIAL SALARY RATES IN EFFECT AT TIME OF SITE VISITS BY HOSPITAL

Hospital	RN [1]	LPN/LVN	Pharmacist	Spec. Techs. [2]	Therapist [3]	Security	Other [4]	Total
A	1	1	1	—	—	—	—	3
B	1	—	1	1	1	—	—	4
C	2	—	1	2	—	—	1	6
D	1	—	1	—	—	1	1	4
E	—	—	1	—	—	—	1	2
F	1	—	1	—	—	—	—	2
G	1	—	1	—	1	1	—	4
H	1	1	1	1	2	1	1	8
I	1	1	1	2	3	1	1	10
J	1	1	1	1	2	1	1	8
K	1	1	1	2	3	—	1	9
L	1	—	—	—	—	—	—	1
M	1	1	1	2	1	—	—	6
N	1	1	1	3	3	1	2	12
O	2	1	1	2	3	1	1	11
P	1	1	1	1	1	—	2	7
Total	17	9	15	17	20	7	12	97

[1] Includes RN and Nurse Anesthetist special salary rates.
[2] Specialized Technicians (Radiology technicians, Medical technicians, heart/lung technicians).
[3] Includes Physical, Occupational and Respiratory Therapists.
[4] Other medical staff (physicians, physician assistant, Engineer, Dental Hygienist).

Chart C displays similar salary rate information, but, for purposes of exposition, groups health care occupations. Technicians with specialized expertise were grouped into a single category, "Technician". These specialty areas were Radiology Technician (9 hospitals), and Medical Technician (5 hospitals) and included Heart/Lung Technician (1 hospital). "Therapists" include physical therapy (9 hospitals), occupational therapy (6 hospitals) and respiratory therapy (5 hospitals). Similarly, the "other medical staff" category is composed of Physician Assistant (2 hospitals), Engineer (4 hospitals), and Dental Hygienist (5 hospitals). Nurse Anesthetist (2 hospitals) was included in the Registered Nurse category.

As can be seen, each of the 16 hospitals have between one and 12 occupations under special salary provisions. In all, 21 different medical staff specialties were represented. The average hospital has six such special salary rates in effect.

The major staffing problem is in nursing with 26 special salary rates for both registered and licensed practical/licensed vocational nurses. Pharmacists are also an important special salary rate occupation with 15 hospitals employing such rates, as well as technical

staff with specialized expertise in such areas as radiology and ultrasound. It is worth mentioning that hospital security personnel are also paid by special salary rates in 7 hospitals.

The management section of the survey included questions about major funding problems for the 16 medical centers for fiscal year 1988. Problems were reported to include the following: Reductions in accounts to pay medical staff together with increased costs of special pay and contract registered nurse costs (12 hospitals); underfunding of within-grade salary increases and incentive awards (4 hospitals); "savings" required as a result of the Decentralized Hospital Computer Program (DHCP), one percent productivity improvement (7 hospitals); Resource Allocation Methodology (RAM) adjustments (4 hospitals); inadequate equipment replacement (11 hospitals); underfunding of AIDS related costs (e.g., treatment, supplies for patients and staff protection, AZT) (3 hospitals).

Other management questions are related to Office of Management and Budget Circular A-76 studies. These included many of the activities listed above (i.e., laundry operations, canteen service operations, transcription services, switchboard and maintenance). Implementation of these activities were all on hold pending resolution of contracting regulations in the VA's central office. Most Efficient Organization (MEO) studies included building management, engineering, medical administration service, dietetics, housekeeping, grounds maintenance and office operations. In general, these showed that VA operations are generally very efficient, or viewed another way, generally understaffed. Most hospitals reported increased efficiency due to suggestions contained in the MEOs.

Three hospitals reported that Facility Development Plans for construction and maintenance were underway, although none were completed.

Discussion

The actual, although unofficial, reduction in the capacity of these VA medical centers to deliver medical services to veterans is significant. It is obvious that fewer beds open and available to veterans means less medical care is delivered. Further, since the official bed capacity is greater than the actual bed capacity, the occupancy rates cited by senior VA officials are artificially low and are not likely to correlate well with hospital demand and efficiency.

Since this survey investigated beds closed due to inadequate staff, some comment about the special salary rate situation is in order. The special salary rates have made it possible for VA medical centers to remain contenders for scarce medical personnel in highly competitive employment markets. Yet, 12 out of the 16 hospitals report that funding sources are inadequate for the special salary rates that have been put in place, and so the attempted solution for difficult staffing problems has itself become a problem.

Funds to meet the new payroll costs have largely come from replacement equipment and maintenance and repair accounts, leaving these latter needs unmet. The decision of hospital directors to transfer funds from other operating accounts to fund personnel

costs have made it possible for the VA medical care system to continue functioning. However, having exhausted such accounts, the hospitals now have no recourse but to reduce capacity. In the near term, inadequate funds for equipment and maintenance are likely to further reduce both capacity and efficiency and to threaten quality of care.

Decreased capacity brings a decreased workload. It is important to note that decreased workload will result in reduced future allocations, since the VA's Resource Allocation Model (RAM) is based on workload. Thus, the downward cycle would be accelerated.

The surveyed hospitals list as critically needed basic equipment: Intensive care monitoring equipment, defibrillators, ventilators, steam sterilizers, nuclear medicine equipment, clinitron beds to prevent bed sores, AIDS prevention items for employees (gloves, masks, goggles, etc.), medications (especially AZT for AIDS), and radiology equipment. This does not include such high cost items as Magnetic Resonance Imagers (MRI) and Positron Emission Tomographers (PET scanners).

The directors of VA medical centers have for several years managed their local resources innovatively, doing more with less. There is no more funding available to be shifted into personnel accounts to meet the realities of medical recruitment and retention. Accounts that have been raided to sustain the system are empty. Without an infusion of funds to meet the special pay requirements, provide replacement equipment and maintenance, and procure supplies for VA hospitals, it is clear that more beds will have to be closed and fewer veterans provided health care.

APPENDIX A

SURVEY OF VA HOSPITALS

NAME OF HOSPITAL_____

DATE OF SURVEY_____

BED LEVELS

1. What is the authorized bed level by clinical service?

Medical	_____
Surgical	_____
Intermediate	_____
Psychiatric	_____
Neurological	_____
Rehabiliation	_____
Blind Rehab	_____
Spinal Cord Injury	_____
Nursing Home Care	_____
Domiciliary	_____
Total	_____

2. What is the operating bed level by clinical service?

Medical	_____
Surgical	_____
Intermediate	_____
Psychiatric	_____
Neurological	_____
Rehabiliation	_____
Blind Rehab	_____
Spinal Cord Injury	_____
Nursing Home Care	_____
Domiciliary	_____
Total	_____

3. What it the bed level that is properly staffed by clinical service?

Medical	_____
Surgical	_____
Intermediate	_____
Psychiatric	_____
Neurological	_____
Rehabiliation	_____
Blind Rehab	_____
Spinal Cord Injury	_____
Nursing Home Care	_____
Domiciliary	_____
Total	_____

4. What is the number of beds closed by clinical service? Give the reason such as ongoing construction, shortage of staff, or some other reasons, etc. If staff shortage is the reason, please indicate what discipline is involved.

Medical	_____
Surgical	_____
Intermediate	_____
Psychiatric	_____
Neurological	_____
Rehabiliation	_____
Blind Rehab	_____
Spinal Cord Injury	_____
Nursing Home Care	_____
Domiciliary	_____
Total	_____

STAFFING

5. List present shortages of staff by discipline (i.e., registered nurses, LPNs, pharmacists, other).

_____
_____
_____
_____
_____
_____

6. List medical staff disciplines for which hospital is currently using special salary rates. List funding source for each and whether funding is adequate to support the rates (e.g., Central Office, Regional Office, local).

_____
_____
_____
_____
_____
_____

7. List major funding problems for fiscal year 1988.

_____
_____
_____
_____
_____
_____

MANAGEMENT

8. List the activity and status of ongoing A-76 cost comparison studies. List the activity and status of ongoing Most Efficient Organization (MEO) studies. List any A-76 or MEO studies that have been recently completed and the results.

9. Describe the status of the Beneficiary Travel program icluding funding year-to-date and comparison with fiscal year 1987.

10. Describe status of Facility Development Plan. If not yet completed, give expected completion date.

11. If there is a waiting list for nursing home beds, give number of veterans on the list and the expected date that the next bed will be available. Describe constraints on the availability of nursing home beds.